FOREIGN BODY AIRWAY OR ESOPHAGEAL OBSTRUCTION

Historical Findings

1. Patient complains of shortness of breath or cannot speak because of airway obstruction.
2. MAY have history suggestive of foreign body aspiration such as sudden onset of shortness of breath while eating.
3. May have complaint of painful or difficulty swallowing, following eating.

Physical Findings

1. Airway exam has little or no air movement, stridor, or decreased breath sounds.
   A. MAY have use of accessory muscles of respiration.
   B. MAY have fever or drooling.
   C. MAY have retractions or rapid respiratory rate.
2. In the presence of an esophageal obstruction the airway exam will be normal and signs and symptoms of respiratory distress will be absent.

Differential Diagnosis

1. Congestive heart failure.
2. Epiglottitis.
3. Croup (in a child).
4. Obstructive lung disease (asthma, bronchitis, emphysema)
5. Spontaneous pneumothorax.

Protocol

1. Initiate contact; reassure, and explain procedures.
2. Assess and secure the patient's airway and provide oxygen per the airway, oxygen and ventilation protocol.
3. Perform patient assessment and obtain vital signs.

4. Consider IV access with a saline lock or 0.9% normal saline KVO.
5. If complete airway obstruction by foreign body is suspected**,** follow the most current AHA Guidelines.
6. If an unconscious patient still has airway obstruction and equipment is available:
   A. Visualize the larynx using the laryngoscope and remove any foreign body with suction device or Magill forceps. (Utilize RSI if needed)
   B. If spontaneous breathing does not begin, intubate the trachea.
   C. If unable to intubate or mask ventlate perform cricothyrotomy.
7. If foreign body esophageal obstruction is suspected in a patient > 15 years, glucagon (glucagen) 1 mg IM/IV may be administered.
8. Allow the patient to sit up in a position of comfort for transport.